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THE CRISIS IN MEDICARE: EXPLORING THE CHOICES

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THE CRISIS IN MEDICARE: EXPLORING THE CHOICES

MONDAY, AUGUST 20, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Rock Island, IL.

The committee met at 9:10 a.m., pursuant to notice, in the Martin Luther King Community Center, Rock Island, IL, Hon. Charles H. Percy presiding.

Present: Senator Percy.

Also present: Marcia Pape, legislative assistant to Senator Percy.

OPENING STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. I'm sorry to delay the proceedings this morning. Our plane was a few minutes late.

I would like to acknowledge the presence of Mayor Davis of Rock Island and Mayor Anderson of Moline. We're appreciative of having them here, very much indeed. I look forward to greeting all of you at the conclusion of the hearing. I won't delay you right now, but I certainly appreciate very much the fact that so many of you have indicated your interest in the subject matter at hand.

This is an official U.S. Senate hearing of the Special Senate Committee on Aging, a committee, I might say, on which I am now the senior member. Every year, I get more interested in the subject matter.

As an official hearing, the hearing will be recorded and will be conducted in accordance with the U.S. Senate rules.

I do find, however, that having such a hearing in the field, particularly in the Quad City area where we have so many in the senior citizen category, is far better than in Washington. I have the feeling that those of you who are here are not just tourists who happen to be in Washington—and those constitute probably 90 percent of our audiences. They're just interested in the process of government—but those of you that are here today are really interested in the subject matter. You're not here just because you're looking at how the Senate operates, but you're here because you recognize that Medicare is a challenge. It's a dynamic program instituted in 1965, but it now affects over 30 million Americans. And if there's going to be a crisis in Medicare and in Medicare funding, then we'd better anticipate it today rather than wait until the crisis is on top of us.

We did this with the Greenspan Commission report on Social Security. I must say, as I went throughout the State and held hearings in Washington and in various parts of Illinois, including near my own home, Evanston, IL—we had a huge hearing there on Social Security—the concerns and fears evidenced to me focused on the system's financing problems. I heard this throughout the State of Illinois, in nursing homes and elderly homes that I've been in—and I've probably been in more of them in Illinois than anyone else in the State, having researched and written a book, "Growing Old in the Country of the Young," a decade ago about the problems of the aging. Fear was one of the great problems. "Would Social Security and its system go bankrupt?" "Would I still get my check?" and "Will my children get their checks?" was a constant hue and cry.

Since the Greenspan Commission, and since the hearings that this committee held on what we should do to make our Social Security system solvent, and since the action of the Congress a year ago, I have not had a single question about the solvency of Social Security. We have assured the Nation and the 36 million elderly and disabled who are recipients of that system that it is here to stay: it is sound, it is solvent, it's been refinanced and, for the first time, as a result of those hearings and the findings, every member of Congress—every Senator and every Congressman—a year ago began paying into the Social Security system. I've been a member of the Social Security system for 40 years, but not a penny of my Senate salary went into the Social Security system. It did for other outside income. But now, we pay in, too That gave us the right—and I fought for that right—to be a part of the system. We still have our Senate pension plan where we pay in 7½ percent. But we pay another 6.7 percent into Social Security. That gave us the right to then say that every new Federal employee must join the Social Security system as a part of coming into the Federal Government. That means millions of new young people will be paying into the system, and by doing that, we make the program equitable.

So, too, at this time we're going to go to work on Medicare, and we're going to try to find out what it is we can do to avoid the crisis that is anticipated, the looming crisis of Medicare expenses, and to examine the various options that we have for reforming the program. Today, we will do so right here with experts in our own community, in the Quad City area, who are qualified to testify.

Medicare was established in 1965 as a means of providing insurance protection for the seniors against the costs of health care. Coverage has since been broadened to include disabled individuals and those suffering from end-stage renal disease.

The Medicare Program has, in fact, been extremely effective, providing protection to millions of older Americans. In so doing, it has become the single largest purchaser of health care in the world. From a program spending only $7.1 billion in 1970, 14 years ago, Medicare spent $58.8 billion last year, and probably will exceed $60 billion this year, 1984

This increase is largely due to the fact that the cost of providing health services has been, as we all know, skyrocketing. Health expenditures in 1983 in all sectors—that is hospital services, physi-

cian services, and nursing home care—increased at rates that are nearly triple the rate of inflation in the general economy.

You know these rising health care costs and what they do mean to your own family budgets all too well. The elderly in our country are faced with special circumstances. For the most part, they live on fixed incomes and are particularly vulnerable to high health care expenditures. Their concern with health care costs extends beyond hospital and doctor expenses, to the tremendous costs of drugs, long-term care, and other costs that often fall outside the realm of Medicare coverage.

It is estimated that older persons will spend an average of $4,202 for health care in 1984, including $1,900 for hospital costs, $868 for doctor bills, and $880 for nursing homes. This is in a year in which we have saved, by the Joint Committee on Taxation's report, the median family in America and in Illinois $1,079 in income tax cuts; but it took a 25-percent across-the-board cut to do that. For the most part, though, the elderly do not have that income from earnings, and when we take into account that health cost alone is four times the entire saving of $1,079, we can see in relationship how big a burden that is on the aging.

Clearly, this health cost inflation has critical implications for the health insurance trust fund as well. Estimates indicate that the health insurance trust fund could be exhausted as early as 1990, just a few year from now. We in Congress must take action to restore solvency to this vital program, just as we did in the case of Social Security.

I can think of no more important mission than saving both the Nation and the Medicare Program from runaway health costs. We must act—just as we did last year with Social Security—to preserve the Medicare Programs, which provide assistance to some 27 million elderly Americans and 3 million disabled persons.

The Congressional Budget Office has outlined three broad areas for reform. First, we can increase revenues, either by raising the Medicare portion of the payroll tax or through special taxes earmarked for Medicare; second, we can increase beneficiary cost-sharing; or, third we can further limit provider reimbursement.

It is evident in evaluating these options that no one sector can or should shoulder the entire burden of saving and preserving Medicare. The choices will not be easy. That is why we must start now to fashion a carefully balanced package between the Federal Government, health care users and health care providers.

This hearing will contribute to the growing debate on how best to address soaring health care costs and the Medicare Program's funding shortfall. This is the first hearing of this kind that I have held in the State of Illinois, by the way, and one of the first that has been held outside Washington. I've asked our witnesses today to comment in particular on their perception of the problems confronting Medicare, the pro and con of various reform proposals, and to evaluate the new prospective payment system and other recent changes to help hold down health care costs.

I look forward to hearing the testimony of the excellent witnesses we have with us this morning.

I'd like now to turn to our first panel, our first witness, and ask that she join us. We're privileged to have with us Carolyne Davis,

Administrator of the Health Care Financing Administration. We appreciate your willingness to take time out of your very busy schedule to testify before us. Your statement and responses to questions will constitute an important part of our hearing record, because HCFA is one of the really key players in the Executive Branch on Medicare issues.

Dr. Davis, if you would proceed.

STATEMENT OF DR. CAROLYNE K. DAVIS, WASHINGTON, DC, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. DAVIS. Thank you, Mr. Chairman. I am very pleased to have the opportunity to appear here today to discuss health care costs, the impact that those costs have on the solvency of the Medicare Program, and to elaborate some on the proposals that we have and are thinking about in order to ensure the continuing financial stability of this particular program.

Certainly the issues which we are looking at are among the most pressing items on the administration's agenda, and they are obviously of great concern to all of us.

Medicare, clearly, is one of the most successful programs and it is meeting the needs of the elderly and the disabled. As Senator Percy said, there are 31 million Americans who now depend upon Medicare for a source of protection against the ever-escalating costs in health care dollars.

The Medicare Program was escalating at a cost of approximately 15 to 18 percent each year until 1982. From 1982 until now we have begun to see some diminution in the rate of growth, but it is still rising, as Senator Percy said, at the rate of three times the rate of inflation.

Fortunately, this administration has been bringing down the overall inflation rate, and yet we still see spiraling costs in the health care sector.

The first year that the Medicare Program was in existence we spent $3 billion, and now we're spending 1½ times that each month. For every minute that I sit here, Medicare is spending $123,000, or, translated, that is $7.5 million an hour, that we are paying for the protection and the benefits for health care for our elderly and disabled. Next year, fiscal year 1985, we will be spending $8.5 million an hour for these programs.

The Senator mentioned that in 1983 we were spending $55.6 billion for Medicare, and that's an average of $1,900 for each beneficiary. In the State of Illinois in 1983, we projected expenditures of $3 billion, or roughly $2,300 per beneficiary. And, indeed, we do find that the Medicare Program will continue to increase roughly at the rate of 12 percent, and in 1985 we expect to be spending a total of $77 billion in that particular year Now, $77 billion is a little hard to exactly interpret, so I think it's easier to think about it in terms of millions. That's $8.5 million an hour that we will be spending.

But we have been successful in slowing the rate of growth in our Medicare expenditures, and that's what's particularly important.

Let me digress for just a moment and explain that there are really two parts to the Medicare Program:

Part A, which pays the inpatient and outpatient bills for hospital care, as well as some home health care benefits, and a small percentage for skilled nursing facilities.

Part B is that part which pays for physicians' care and some of the outpatient costs, medical supplies and equipment, and additional home health benefits.

We are financed by two different mechanisms. The Part A program is the part into which each individual pays part of their Social Security taxes throughout their entire employment period. Those taxes are put into a trust fund, and it is that trust fund that is in jeopardy.

Part B is an elected option that the individual who is entitled to Medicare may elect to pay premiums for at the time that they are entitled to the part A benefit program. The individual pays a monthly premium of approximately $14.60 this year, and that then pays for part B.

It is part A that is the problem in the future. That is the trust fund that faces the danger of becoming insolvent.

The actuaries for the Health Care Financing Administration have indicated that, looking at what we call the intermediate assumptions—not the most pessimistic and not the most optimistic, but the intermediate assumptions—the program has a potential for becoming insolvent in 1991.

Now, as the Senator indicated, there are several possibilities for how we can go about shoring up this particular program. First of all, in order to remain solvent over the next 25-year period of time—and the actuaries look at 25-year projections—we would need to decrease the outlays—in other words, decrease the dollars that are going out of the trust fund—by some 32 percent or we could increase the taxes coming into the trust fund by 48 percent. So keep in mind that's over a 25-year timeframe.

We do have some cause for optimism, however. We have succeeded in reducing the rate of growth in the Medicare area as a result of this administration's efforts to bring down the overall inflation rate.

Second, we are finding that with increased competition in the health care industry, we are beginning to see a slowdown again in the outlays, because we are looking at alternative ways of delivering high-quality care, rather than simply utilizing the highest cost care, which tends to be that of the hospitals, for all the health care benefits.

Finally, we have also introduced into the hospital payment system a new payment mechanism, called prospective payment, and that has the potential of bringing down the overall outlays in this particular part of our program.

In conjunction with looking at proposals in the future to improve Medicare's solvency, we will continue to look at enhancing the idea of competition. We believe the problems in Medicare have largely grown as a result of its being immune to the marketplace, because of the methods by which we have paid.

Let me use this example. In the hospital area, we have been paying, until this last October, under what we call the retrospective or cost-based system. In other words, the hospital would charge the Medicare Program after the fact, after what specific treatments

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were involved. In effect, we had no incentives in that particular program for any kind of efficient behavior. We really had a blank check for the hospitals to fill in. The more the hospitals spent, the more we would pay, since there weren't incentives there for efficiency, and there was no encouragement to think about the cost consequences of the behavior pattern.

Over a period of years, from about the mid-seventies on, we found that there was an attempt, through regulatory intervention, to try to control these escalations in cost, and it was pretty clear that that was not working. And so we embarked upon reimbursement reform by developing the prospective payment system. President Reagan signed this as part of the Social Security amendments that were passed by Congress in 1983, and beginning in October of this last year we began to phase all the hospitals into this new payment system. By this October, we will have all of our acute-care hospitals being paid under the new methodology, which sets a fair rate of payments that is determined in advance for each one of a number of diagnoses. It is an effort, in effect, to allow the hospital an operating margin, but to say to the hospital, "We want to encourage your efficiency, and as a reward for that, you can keep the extra dollars if you bring your own costs in under these particular dollars that we will give you." On the other hand, the hospital will be at risk if it goes over, for it will have to absorb that kind of inefficiency. And we've had some significant changes in behavior as a result of instituting this new system.

We expect to continue to look at ways to reform various parts of the reimbursement system in the future. We are due to send to Congress a report on how to bring the cost of construction for hospital facilities into the new payment system. Likewise, we have a report due next July to Congress on the advisability and feasibility of integrating the physicians payment system into prospective payment. And then eventually we will also be looking at the smaller components of the dollar outlays, such as home health care and skilled nursing facilities.

It's a very complex set of issues, but clearly they are issues that we do need to address. In relationship to the physician area, this is the second largest area of the flow of dollars. And while it is under the Part B program, I'd like to just digress for a moment and explain that the premiums only cover a quarter of the cost of the part B program. When Medicare was initially formulated, the premiums were calculated to pay 50 percent of the cost, and the Federal Government, under the Federal budget outlay, paid the other 50 percent. But over the years, the part that the premiums have been covering has been decreased so it's only 25 percent. The result is that 75 percent of the dollars come from the Federal payment system itself, or the budget. And all of us know that the budget does have some problems in terms of the overall deficit.

It was their concern for that, and recognizing the fact that the physician rate had been growing, again, roughly at three times the rate, that Congress instituted a freeze for 15 months on the physician payment mechanism in order to prevent the need to increase the premiums for the beneficiaries.

In relationship to the other types of reform in the system, in addition to reimbursement reform, we expect to continue to encour-

age the development of alternative delivery systems, the use of ambulatory surgical centers, and the use of a capitated prepayment system such as for health maintenance organizations. We've found that those activities can significantly reduce our outlays.

Finally, too, we believe that increasing the consumers' awareness of costs, and increasing their awareness of the benefit program can allow them to make a more informed selection of their own health care services. In that light, we expect to be publishing a directory of those physicians who do take assignment. That directory should be available somewhat after the first of October of this year.

We continue to encourage individual beneficiaries to seek second opinions prior to surgery, and to become more aware of the cost consequences of their decisions.

In summary, I'd like to point out that in 1982, the Social Security Quadrennial Council, which is mandated by Congress to meet every 4 years, met to begin to consider the future of Medicare. That particular commission report was filed with Congress in March of this year and contains a number of recommendations that look at the preservation and the integrity of the Medicare trust fund. And we will clearly be considering some of those provisions as we look forward to the future solutions. But I think our major effort has been to try a variety of these reform packages which will clearly change behavior, change expectations, and lead to a reduction in inappropriate utilization of services. Therefore, we will be able to have those dollars for payment to beneficiaries who truly need the care of the program. The administration does pledge its full support for solving this problem. We've already been able to delay, we believe, the insolvency of the part A trust fund until at least 1991, maybe 1992, as a result of the more recent changes that we've seen. But clearly we need to guarantee the viability of the Medicare trust fund for all of those who will need it, and we stand determined to do this, Mr. Chairman.

Senator PERCY. Without objection, your prepared statement will be inserted into the record at this point.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF DR. CAROLYNE K. DAVIS

Thank you for the opportunity to appear here today to discuss health care costs, their impact on the solvency of the Medicare Program, and proposals to assure the continuing financial stability of this program. The situation and issues which I will present are among the most pressing items on this administration's agenda and are obviously of great concern to everyone in this room.

Medicare, which is one of our most successful programs, has been critical to the elderly and disabled over the last two decades in meeting their basic health care needs. Without Medicare, the almost 31 million citizens who are dependent upon it would be deprived of a basic source of financial protection and emotional security. As a Nation, we cannot let lapse a longstanding commitment to the continued affordability of health care for our older citizens. However, the growth in health care costs has placed heavy demands on the Medicare Program and its resources. We must continue our efforts to control costs in order to ensure the viability and reliability of Medicare in the future.

CONTROLLING THE GROWTH OF HEALTH CARE COSTS

The rise in health care cost has been the major cause of excessive growth rates in Medicare. In 1965, when Medicare was enacted, the cost of an average hospital stay was $316. In 1982, it was $2,493. In Medicare's early years, we were spending about $3 billion a year on this program—now we are spending 1½ times that much a

month. In fact, every minute that I sit here talking, Medicare is paying $123,000. In an hour, we are spending $7.4 million.

Expenditures have grown from $14 billion in benefits in 1975 to $34 billion in 1980, and have almost doubled since then. In 1983, Medicare benefit payments totaled $55.6 billion. This amounts to an average of about $1,900 in services provided to each beneficiary. Medicare beneficiaries in Illinois received about $3 billion of services in 1983, or about $2,300 per beneficiary. In 1984, we estimate that Medicare expenditures will total almost $69 billion and will grow about 12 percent to more than $77 billion in 1985. So, although we have slowed the rate of growth, Medicare expenditures continue to increase year after year.

Health care consumes an ever larger portion of our Nation's output—10.5 percent of the gross national product in 1982, compared to 6 percent in 1965. Employer contributions for health care premiums alone came to $55 billion in 1981, about 22 percent of all personal health care expenditures. It has been reported that the single largest expense in manufacturing an American made automobile is not steel but workers' health insurance.

TRUST FUND PROJECTIONS

The increasing costs of health care in this country, reflected in the growth of Medicare expenditures, have profound implications for the continued viability of the Medicare health insurance (HI) trust fund. The Medicare board of trustees report, issued in April of this year, projected that the HI trust fund would be completely depleted by 1991 and could have a potential deficit in excess of $200 billion by 1995.

In addition, the two basic indicators of the financial status of the program—a short-range measure, the "trust fund ratio" of the annual beginning balance to the year's outlays and a long-range measure, the "actuarial balance" of the trust fund as a contingency reserve—indicate that the program is inadequately financed, and the reserves of the program are inadequate to maintain financial viability. To assure adequate financing for the trust fund, either program costs will have to be reduced by 32 percent or hospital insurance payroll taxes will have to be increased by 48 percent.

CAUSES FOR OPTIMISM

However, there are a number of new factors that were not present when the trustees' latest projection was made, and we beleive that they will have a positive effect on Medicare finances.

First of all, the inflation rate for hospital costs has dropped dramatically, as Secretary Heckler recently announced. This has been the administration's strategy from the outset. When this administration took office, health care costs were growing an average of 16 percent a year. Last year, we managed to cut the rate of growth in medical care costs to 8.7 percent, largely because we succeeded so well in bringing inflation down, but also because of a series of measures we backed that put the health care industry on a more competitive footing.

Second, hospital admissions are declining rather than increasing as originally estimated.

Third, the increase in payment rates to hospitals after 1986 is at the discretion of the Secretary, which allows for tight constraints if appropriate and needed.

PROPOSALS FOR IMPROVING MEDICARE FINANCING

Still, there remains unfinished business. Part of the growth in health care expenditures can be attributed to advances in medical technology which gave us such marvels as coronary bypass surgery and the CAT scan. The growth of our Nation's elderly population, who use proportionally more health care services, has also contributed to increased expenditures. However, there are other, more fundamental reasons for the escalation of health care costs. One of the primary reasons is that our health care industry has been without price competition because it has been immune from the forces of the marketplace. Because of this, hospitals and other providers of care have had no incentives to operate efficiently. In addition, employer-financed health insurance along with government-financed health care programs have shielded both patients and providers from the true cost of health care. Over the years, the only approach to countering the effect of these disincentives to the efficient use of our health care resources has been the ineffectual attempts of government to impose limits through regulations. This has not worked. In the end, regulations only offer an incentive to beat the system which leads to more regulation in an attempt to avoid this. Clearly we must stop relying on regulations and look to

the classic incentive for efficiency provided by the marketplace—in short, competition.

In 1981, for example, we backed legislation that put Federal dollar limitations on Medicaid and at the same time gave States the flexibility to develop innovative programs for delivering care more effectively, this has slowed Medicaid's annual increases appreciably.

In 1982, we worked with Congress to enact the Tax Equity and Fiscal Responsibility Act (Public Law 97-248) that took a big, first step in reforming the Medicare hospital reimbursement system by providing payment on a per discharge basis and by providing financial incentives to control costs. This new system reversed the negative of the previous cost-based reimbursement system that had little need to be attentive to the possible overutilization of services.

Last April, the President signed into law the Social Security Amendments of 1985 (Public Law 98-21) which contained the most significant change to the Medicare program since its enactment. This change, of course, is the prospective payment system under which hospitals are paid a prospectively determined rate per discharge based on diagnosis related groups that reflect the cost of caring for every kind of illness. Prospective payment will reward hospitals that provide care efficiently and force the rest to absorb the cost their inefficiency.

The full impact of this system will not be felt until its 3-year phase-in is completed, but since it began last October it has already had a beneficial impact. About half of our hospitals are now being paid under this system and, contrary to expectations (as mentioned earlier), admissions have not met projected increases. In fact, our figures show a slight decline in admissions. The average length of a hospital stay in all hospitals has also declined from 9.7 days to 9 days and the average length of stay in just those hospitals under the prospective payment system was 7.5 days through May of this year.

And this is not the end of reimbursement reform through prospective payment. At Congress' direction, we are now studying how additional areas may be brought under prospective payment, including hospitals' capital costs and physician services. We are also preparing recommendations on how to apply the prospective payment principle to skilled nursing facilities and are developing possible prospective payment models for home health agencies.

The congressionally mandated study on the advisability and feasibility of including physician services in the prospective payment rate is particularly important since the decisions physicians make account for three-quarters of all the money spent for health care. Medicare's bill for physicians' fees consumes over 20 percent of program expenditures and represents, after hospital costs, the second largest item in our budget. If we were to pay physicians prospectively, we would give them a powerful incentive to treat their patients as cost-effectively as possible. However, we realize that this is a complex issue that must be completely evaluated before taking action.

The recently enacted Deficit Reduction Act (Public Law 98-369) contained several of our proposals to slow the rise in Federal health care costs and help us meet our obligation as trustees of public funds. A key provision of this act, similar to our proposal, will freeze physicians' fees paid by Medicare for 15 months. This should reduce the need to raise the part B premium paid by beneficiaries.

In addition to efforts directed at reimbursement reform, we are also studying alternative delivery systems to determine if there are better ways to provide necessary care in a cost-effective manner. For example, we are evaluating the use of ambulatory surgery centers as an alternative to inpatient care for certain types of procedures. We are also assessing alternative models of prepaid, capitated health care systems and are encouraging health maintenance organizations to enroll Medicare beneficiaries. Another demonstration will look at providing acute and long-term health and social services to patients under a capitation system of payment.

In addition to reimbursement reform and the development of alternative delivery systems, a third element in our strategy to control Medicare expenditures is to make the consumer aware of the true cost of health care. I mentioned earlier that health insurance and government health care programs isolate the patient from realizing the cost of care. Consumers need to become knowledgeable about the types of services available in various settings, the cost of these services, and the coverage of services by various insurance packages. Without this information, consumers are not well prepared to make appropriate choices in the utilization of health care. We are publishing directories of physicians who take assignment in order to provide beneficiaries with more information when choosing their personal physicians.

As you know, beginning in 1982, the Advisory Council on Social Security undertook an indepth review of Medicare. On March 8, the Secretary forwarded to Con-

gress the Council's recommendations for preserving the integrity of the Medicare system. These recommendations will be considered as the Department develops further solutions to Medicare's financial problems.

CONCLUSION

Medicare's financial problems are complex and will require the efforts of all sectors of the health care industry—both public and private—to restore the stability necessary to meet the future needs of beneficiaries. The actions we have taken to date will certainly have a positive impact on the financing of the program, but we will have to continue our efforts until we can assure beneficiaries of Medicare's viability while remaining fiscally responsible to the American public.

That concludes my prepared remarks. I would be glad to answer any questions you have.

Senator PERCY. Dr. Davis, I thank you very much, indeed. I think it's interesting, if I take your figures that you gave in your opening statement, that during the course of this hearing, 2 hours, Medicare payments will be $50 million.

Dr. DAVIS. That's correct.

Senator PERCY. And that gives us some perspective on how much money is going out.

Could you give us a little feeling, Dr. Davis, of the size of your own administration, how many people report to you, how large an organization it is, and how many people are you servicing? Are 31 million people, including everyone in this room who is eligible for Medicare, under your direction?

Dr. DAVIS. Yes; we have a staff of 4,053 individuals who do the servicing for the beneficiary population. And our beneficiary population covers not just the 31 million who are on the Medicare Program, but also the 20 million who are in the Medicaid Program, because our Health Care Financing Administration is responsible for the oversight of both Medicare and Medicaid.

Senator PERCY. So you run one of the biggest businesses in America.

Dr. DAVIS. I believe I do, at this point in time.

Senator PERCY. That's what I mean when I say how much we appreciate your coming out from Washington to do this. I hope it will help you as we develop this whole hearing, and help the administration. We will make available, of course, the full testimony to you.

As I reviewed your prepared comments, you mentioned that the average beneficiary in the United States received $1,900 in services, while the average Illinois Medicare beneficiary received $2,300. That's $400 more in services. What accounts for that difference? Is health care more expensive here in our State, or do the Illinois beneficiaries use more services?

Dr. DAVIS. I think, Senator, I'd have to say that it appears that the health care costs are more expensive here in Illinois. You have to look at several factors.

We looked at utilization patterns and at client patterns, and it seemed quite clear to us that it was a combination of the fact that the 1982 data, which are the last data that we had—and that's from the data that we quoted—indicate that the length of stay for patients who do enter the hospital in Illinois seems to be about a day more than it is in the average national. And, of course, a day of care——

Senator PERCY. So it's not only more expensive per day, but there seems to be an average of one day more, for the same kind of an illness?

Dr. DAVIS. That is correct. And when we look at the reason why it's more expensive per day. I think it has to do with two factors. It appears that there's a slightly higher salary cost here than the national average, and it also appears that there are more full-time equivalent workers per patient than there are in the rest of the country. So it's a combination of those.

Senator PERCY. The Federal Government took a major step in 1983 to control its health care expenditures by reforming the Medicare reimbursement method for hospital services. I'm not aware, though, of any major achievements in reducing rates of increase elsewhere in the health sector.

What do you envision for other reforms in the future?

Dr. DAVIS. We are publishing in October a new method of payment for a capitated approach on a risk-based system, called the health maintenance organization. We have had some demonstrations—roughly 60 of them, around the country—for our Medicare population, and we've found that the quality of care is every bit as good as it is in the regular system. So we will be publishing the final regulations to encourage further development of the health maintenance organizations.

I think this is particularly significant because we will be paying only at the rate of about 95 percent of what we would normally pay, and yet the volume of services appears to be appreciably more. There has been a decrease in the number of days in hospitalization, but they've been adding more preventive services and continuity of care for the Medicare beneficiaries.

So I think we will continue to expand in that particular area, Senator.

Senator PERCY. Another area that I hope will be expanded, as long as I lived under 28 years as an industrialist and businessman, is increased competition and less regulation. I wouldn't have gotten here on Mississippi Valley Airlines if my bill hadn't deregulated the airlines and opened up more cities to competition.

In your testimony you're strongly advocating the use of competition to regulate health care costs, as opposed to Government regulation. I agree. But how do you envision competition being introduced into the health care field to achieve this result?

Dr. DAVIS. I think we're beginning to see——

Senator PERCY. It's not a for-profit business, for the most part, though it is in some sectors.

Dr. DAVIS. That's correct. I think there's a variety of factors. About 1½ years ago we published regulations that would pay for services outside of the hospital in an ambulatory surgical center. We're now finding a significant increase in free-standing ambulatory surgical centers and in outpatient surgery. This is very important, because it provides an alternative to going into the hospital. And, of course, going into the hospital is, again, our highest-priced service area.

Likewise, we published regulations that will pay for care in a hospice, as an alternative, again, to being hospitalized. We're finding various alternatives, such as surgical centers, allergy centers,

primary care clinics, that are open around the country—again, alternatives to being hospitalized. Payment for preadmission testing is another area that we continue to encourage, and we're finding, again, some of these free-standing clinics are available to do that kind of referral.

All of these are, of course, in direct competition to the hospital itself, and I think we're finding that in addition to competition in services, we're beginning now to see competition in pricing, competition in qualitative services, too.

As the occupancy rates in the hospital industry fall as a result of these kinds of competing demands, we're seeing that the hospitals are now beginning to look towards offering a spectrum of services or actually reducing their price per service in order to compete in the marketplace.

Senator PERCY. One of the programs that Teddy Kennedy and I started together is the nutrition program. We have a number of them here in the Quad City area, serving lunches for elderly people—that is, those over 65. They can contribute what they can, and it helps a great deal. We also have Meals-on-Wheels that we started, again, years ago. And it's been a wonderful thing to provide for people in their homes so that they don't have to be institutionalized if they have a broken hip or something and can't fix one hot meal a day at least.

What is your feeling about the idea of trying to find other incentives for taking care of people in homes, if possible, even if we go to a tax credit system? Is there some incentive we can provide for that? Should we continue trying to pursue that, in view of the extraordinarily high cost once they're institutionalized?

Dr. DAVIS. Well, clearly, I think that we've been interested in looking at a variety of alternatives for providing care outside of the institution itself, because it is very clear that many of the services can be provided in the home at a cost that is no greater than it is in the institution itself. The trick is to define which population would have been at risk of being institutionalized, and learning to target those particular resources to only those individuals. The danger, of course, is that if we don't target it appropriately, we would open it up and simply pay more for everyone's care. Some of them could actually take care of those needs themselves. And, of course, we're all aware of the fact that the Medicare trust fund is precarious in its overall balance, so we are carrying out a number of demonstrations to look at how do we learn how to identify correctly and to target those individuals that are most in need.

There are three or four States that offer tax credits, and we are looking at those particular States and trying to study the outcomes to find out if that's appropriate. I think in the next 2 to 3 years we'll have a much better understanding of how we target those services.

Senator PERCY. Dr. Davis, could you give us a brief explanation of the prospective payment system. Then, because it is generally assumed that the prospective payment system is going to make hospitals more efficient, I wonder how we know that the quality of service is not going to suffer under it. Have plans been made by HCFA to monitor the prospective reimbursement system to see that the quality doesn't diminish?

Dr. DAVIS. Yes, I'd be happy to.

The prospective payment system is based upon a system that we tested for about 7 to 10 years in various demonstrations around the country, primarily in one or two of the States. When we were doing that testing we carried out a 5-year study that looked at the quality of care. It was done by an outside association. We found that, looking over the 5-year time period, at approximately 2,900 hospitals, using 600,000 of our beneficiaries, that the quality had not changed during those 5 years. What had changed was behavior. They'd learned to live within a budget when we gave them a budget. That was very heartening to us.

So when we moved in to develop the system, what we did was to say, "We will use 468 separate diagnoses. These will be the kinds of diagnoses that fall into a broad enough category that the individual who goes into the hospital will fall into one of these particular categories." We've also done historical studies based upon the hospitals' cost data that they've submitted to us, and we could then tell what the appropriate cost for care for the different categories are.

For example, it costs more to take care of a patient who has an injury to his head and has to have brain surgery than it does for somebody who has a cataract removal, which is a relatively simple procedure. Since the resources are very dependent upon the illness of the patient, that, then, allows us to give a budget target for the individual hospital. And it's like everything else; when you're given a budget—as we all learn to live within a budget—the hospitals, too, are changing their behavior patterns to learn to live within that budget, because they are at risk if they go over it. They have the incentive that if they stay within that budget, they keep those extra dollars, and they can use those dollars for equipment or for whatever other expenditures they would like.

Now, there are two dangers. When you're paying out, as we are, $44 billion this year to pay for hospital inpatient care, and you're paying that on the basis of the per-case admission, a hospital could cut corners and in that way save dollars, or they could send a patient home and readmit them in order to, again, make more dollars. I doubt that that would happen, but there are occasional times when somebody in a system that's that large would like to maximize their reimbursement inappropriately.

And so we created a monitoring mechanism, a peer review, medical review group, that looks at the quality of care. Roughly a quarter of all the admissions are being looked at. Some of them are being looked at randomly, some of them are being looked at very specifically. For example, last year we found that there was a tendency to overutilize pacemakers, and so we have all pacemakers under medical review. We have the ability to target a specific diagnosis if we feel that it has a potential for any inappropriate utilization of activities.

But I think that the behavior of hospitals and physicians would indicate to me that most of them are concerned about delivering high-quality services, and particularly as competition comes into the system. So I doubt that we're going to see much diminution in quality of care. But just to protect that, we do have our medical review.

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Senator PERCY. Thank you very much.

I'd like to get your view on doctors' reimbursement. As you know, I've been kicking around doctors quite a bit the last year, mainly those who I've found have not been paying their student loans or grants, who have walked away from their obligations of $60,000 or $70,000 of payments that I felt they were able to make. We've been seizing their cars, garnishing their fees and doing everything we can to cause them to pay. And they are beginning to pay up.

I met with the American Medical Association board in Chicago to notify them we were going to go over the doctors, and we had their unanimous support in so doing. They felt they were deadbeats and we ought to go after them. But doctors, for the most part, in this country are the finest, I think, offering the finest service and most dedicated service of any nation on Earth, under our system.

Dr. Burke, later this morning, is going to address physician reimbursement from a doctor's point of view, and I wonder if you could do it from an administrator's point of view. What do you see as the effect of mandating assignment on physicians treating Medicare patients?

Dr. DAVIS. Clearly, we've been concerned about looking at the whole area of reform in the physician reimbursement area. In fact, Congress has mandated that we do. We, in this administration, are opposed to mandating assignment. I do think, however, that the current system does not foster the same kinds of incentives as we now see on the hospital side.

If you look at the significant growth in the part B area, we find that it's been growing, again, at the rate of about 16 to 18 percent a year. And so, again, we know that we have to do something about that.

When we look at what is causing that rate of growth, we find that roughly 44 percent is due to an increase in the utilization of a number of services, and about 44 percent is due to simple cost inflation. And then, roughly, what is left is due to an increase in the population itself.

So we felt very clearly that we need to reform the system of payments. Meanwhile, we had to do something to begin to stop this kind of an outlay, and so we did support the physician fee freeze for one year as a temporary measure while we begin to look at how we ought to reform the system of payments to physicians.

The concept that Congress came up with as a part of the fee freeze was, if you will, to encourage physicians to voluntarily seek to participate in the program by signing up as an assigned physician, and we will publish a directory. They have until October 1 to make their determinations, and then sometime in the month of October we will publish the list of participating physicians by areas of the country, and those will be available to all senior citizens organizations and to the Social Security offices.

In addition, the carriers themselves will have a toll-free number that the beneficiaries can call to get that kind of information.

As an added incentive, we have indicated that for physicians who do voluntarily participate in the assignment program, they can actually, in fiscal year 1985, increase their charges, and we would recognize these charges. Although we wouldn't pay for them this

year, they will be calculated into their payment systems in 1985. For the nonparticipating physician, that would not happen.

Senator PERCY. Thank you. It is apparent that anything we do in the future in the way of reform has to zero in on the inflation that is occurring in the health care field, and we have to do it in a way that avoids simply cost shifting measures, where we save someplace but then someone else has to pay for it.

My last question concerns the evidence that you have that cost-sharing proposals would alter beneficiary behavior and act as a brake on ever-escalating costs. Do you think that it will? Given the fact that the vast majority of health care decisions are made by physicians, is it fair to assume beneficiaries could alter their utilization patterns on their own?

Dr. DAVIS. Yes. We know that from some studies that have been done. The Rand Corp. has carried out a very large study, looking at the impact on the utilization of services. What they found is that with an increase in copayments or deductibles, the amount of ambulatory services did go down some, but the needed services for inpatient care or other types of skilled care did not change at all.

So its impact is primarily in the utilization pattern of the initial seeking of the service, and primarily in the outpatient areas and some of the ambulatory services. But I think also what we found is that as the consumers are more aware of the variety of services, they're now beginning to feel comfortable asking the physicians, "Is this a needed lab test? Is this a needed service?"

We've found, too, that in the private sector they're beginning to encourage the same type of behavior by many in the business community by saying, "We'll send you back your entire hospital bill, and if you see something on there that you think wasn't delivered to you, you question that and we'll share those dollars saved."

I think we're beginning to be more comfortable about questioning the activities in the health care sector, and that's important, because I think we all need to recognize that we need to continue to be vigilant about inappropriate utilization of services.

Senator PERCY. Your immediate superior is Secretary Margaret Heckler.

Dr. DAVIS. That's right.

Senator PERCY. What is the size of the total Health and Human Services' budget?

Dr. DAVIS. It is larger than any other country, except the U.S. total budget, and I can tell you it's up around $300 billion.

Senator PERCY. Larger even than the Defense Department's budget.

Dr. DAVIS. Yes, it is; much larger.

Senator PERCY. So——

Dr. DAVIS. By, I think, about 10 percent.

Senator PERCY. As a little boy 5 years old, I used to sell the Ladies Home Journal—"Never underestimate the power of a woman," was their motto at that time, and still is, I think. So, we can't underestimate the power that you have together with Secretary Heckler.

If you don't mind, I intend to speak to her about my great admiration through the years for what I've seen as the totally dedicated professional service that you offer. I think it's very, very rewarding

to have all of my friends here in the Quad City area recognize the kind of job that you do. It's a superb job, and the dedication of your administration is outstanding.

I'd also like to advise today, in Decatur, a recipient of your program, and someone who will look forward to receiving your services in the future when he gets old enough to really have them, the President of the United States, who we will greet down there at 1:45. I intend to tell him in the 3 or 4 hours that we'll have together in Decatur what an absolutely superb job I have seen as a businessman, in the business of running our health services which is being done, particularly with respect to 31 million Americans plus the others that are covered by Medicaid.

I thank you very much, indeed.

Dr. DAVIS. Thank you, Senator. [Applause.]

Senator PERCY. Our next panel consists of Boyd McIntire and Al Halx, representing a number of senior groups here in the Quad City area. I wonder if you both would come forward, please.

I would like to announce that, for all of our subsequent witnesses—because the hearing is limited this morning because of the necessity of my departing to go down to be with the President—we've asked our witnesses to present their testimony in 7 minutes, their oral testimony, to leave time for questioning. The full content of their testimony will go in the record. So if we could hold to the 7 minutes time, it would be helpful I've asked our staff director today to notify each one of them when they have a minute left, in order to give them some notification.

Mr. McIntire, we'd be very happy to have you begin. Boyd McIntire, of Rock Island, president of the Moline chapter of the American Association of Retired Persons, and secretary of the Illinois Council on Aging.

STATEMENT OF L. BOYD McINTIRE, ROCK ISLAND, IL, PRESIDENT, MOLINE CHAPTER, AMERICAN ASSOCIATION OF RETIRED PERSONS, AND SECRETARY, ILLINOIS COUNCIL ON AGING

Mr. MCINTIRE. Senator Percy, ladies and gentlemen.

I am 74 years old, and a user of the Medicare system.

Two major problems face the old—Medicare solvency and the part that the old will play in the balancing of the Federal budget. The projected collapse of the Medicare hospital insurance trust fund by 1988 or 1990 is frightening. Many of the old believe that after the elections, there will be drastic changes in Medicare, with the old paying increased costs. A closely aligned problem is concern about the balancing of the Federal budget. Whenever the talk is about balancing by cutting domestic programs, a principal target is Medicare and also Medicaid, which is 9 percent of the Federal budget, according to the Congressional Budget Office.

Senator PERCY. Mr. McIntire, I might interrupt to say that that's exactly why I decided to hold this hearing before the election, so we get right on record what the problems are, and that we don't try to paper them over until after the election. These are the problems we've got to solve, and everyone who is in the electoral proc-

ess had better brace themselves to face up to these problems. Thank you. Please continue.

Mr. MCINTIRE. Medicare is important to us. With the advent of Medicare in 1965, the old had good medical care for the first time in American history. Because of the nature of the aging process, the old use the health care system more than any other age group. We, the over-65 group, spend 15 percent of our total income on health care, use 25 percent of the drug prescriptions, and pay one-half of the total nursing home care costs.

We may complain about our aches and pains, but because of Medicare we are healthier, we live longer, and are more active in our later years.

There are many suggested solutions to the Medicare problems. One that AARP favors is to put a cap on hospital costs by legislation and create a cost-containment plan that applies to all payors across the board. The villain in the Medicare crisis is the rapidly rising hospital and doctor costs. Because the health care industry is unable or unwilling to control these costs, control by legislation is the only sound solution.

AARP also supports legislation by the States to regulate hospital costs. Six States have comprehensive hospital cost containment programs. According to data from the American Hospital Association, during 1982 and 1983 nonregulated States had a 16.3 percent increase in hospital rates, compared to a 10.8-percent increase in the regulated States.

Three other States have just passed legislation to establish mandatory prospective payment systems. In addition to these, the Governor of Illinois has recently signed into law "The Illinois Health Finance Reform Act." Its main purpose is to develop cost data for future price regulation, if hospital costs rise faster than the general inflation rate.

Another proposal is to cut Medicare benefits by raising the deductible, which is what the patient pays before Medicare will start to pay, and starting coinsurance from the first day of hospital stay. Now, AARP is opposed to this, as it would not control the rising cost of service. It would impose a staggering financial burden on the old.

Today, out-of-pocket costs for the old for health care are $1,550 per year. By 1996, according to AARP data, it will cost $7,610 per year, if all of the Medicare deficit is shifted to the old. The Congressional Budget Office projects that by 1996 the Medicare deficit will be from $300 billion to $400 billion if the rapid rise in hospital costs continue.

Another popular suggested solution is to means test Medicare, which means to decrease or stop benefits to those who have the ability to pay. In 1965, Congress, in its wisdom, created Medicare as an entitlement, open to all at the age of 65 regardless of income. To means test Medicare would change the thrust or philosophy of the entire program. To avoid the stigma of welfare, many of the old would go without proper medical care, and, I might add, probably most of the old would go without proper medical care. This was a situation that Medicare was designed to eliminate. How much money would be saved by means testing is in doubt, when one considers the administrative costs of such a program.

Proposals to put more tax money into the Medicare system are also opposed by AARP. The young already pay heavily into social security and Medicare. Additional payroll and other taxes would just create a burden on them and create intergenerational conflict, and there is enough of that currently about the Social Security system.

The present quality of life of those over 65 is the highest in history. Some gerontologists paint a picture of the projected numbers explosion of the old as a golden, glorious age for the old, with better incomes, better health, increased activity and happiness. Other gerontologists, equally as learned, equally as famous, claim that there will just be more illness, poverty, senility, and that more of the old will become a burden to society. Regardless of who is correct, Medicare must bear the brunt of the medical care of future generations of the old.

In conclusion, I urge you, Senator Percy, to:

First, resist any drastic changes in Medicare benefits. We recognize that there will be changes, and that in fairness some of these we must accept.

Second, to resist the means testing of Medicare. We should keep intact the philosophy of a program that has worked quite well.

Third, and the most important thing, the one that gets to the heart of the problem, to work for legislation to put limits on hospital costs, and an across-the-board cost containment plan.

Thank you. [Applause.]

Senator PERCY. Thank you very much, indeed.

I must say, I don't have a conflict of interest. I have a great interest, and I will declare my membership for many years in the AARP and my devotion to the interests that you have always taken as an organization in absolutely vital matters.

Now we will hear from Al Halx, chairman of the Western Illinois Advocacy Project, Rock Island, IL.

STATEMENT OF AL HALX, CHAIRMAN, SENIOR EDUCATION, INC., WESTERN ILLINOIS ADVOCACY PROJECT, ROCK ISLAND, IL

Mr. HALX. Well, I'd like to say good morning, ladies and gentlemen, and good morning, Senator Percy.

My name is Al Halx, and I am chairman of the Senior Education, Inc., which is a nonprofit organization which helps seniors in a 10-county area in western Illinois advocate on their own behalf.

Before beginning my testimony, I would like to thank the Senate Special Committee on Aging, and you, Senator Percy, for coming to Rock Island to learn our opinions and suggestions about Medicare. Of course, I would also like to thank you for your invitation to speak today.

Medicare truly is heading into crisis. With it is the future health and well-being of older Americans. Your presence here today demonstrates the critical prognosis we are all becoming so familiar with. The older persons we work with are concerned about the financial health of the system, but they are equally concerned about the remedies being prescribed.

Senator, you captured the promise of Medicare in your book, "Growing Old in the Country of the Young," when you stated:

Medicare * * * was one of the most significant pieces of social legislation in the history of our country. It was a first step toward making health care a right rather than a privilege.

I am here today to urge you to take the next step forward, rather than the next step backward.

Two basic options are available—reduce expenditures or increase revenues. A combination of these two approaches will no doubt be required. It is the exact mix of these approaches that I would like to address in my testimony today.

The importance of finding the best solution to Medicare's financial problems are indeed on the minds of many we know, especially those living on low incomes. It is important to Dorothy Harmon of Rock Island, who is currently undergoing tests in the hospital. Dorothy lives on a limited income and has been absent from her part-time job due to this recent illness. Dorothy's ability to maintain her supplemental Medicare insurance policy is directly related to her working her part-time job. Dorothy stated:

Keeping up will really be difficult, because I am not working now. We'll struggle through, but I do not know what we will do this winter when fuel bills begin.

Increased deductibles and copayments for Medicare will place an added burden on Dorothy. Her gradually increasing health insurance premiums will also add additional economic troubles. With the rapid increases in health care costs, there are many that we know that will not seek health care services because they fear they will not be able to pay.

For Ray Perry of Rock Island, the biggest problem with Medicare is the difference between what most doctors charge and what Medicare pays. He states that "A lot of people are not able to talk to their doctors about their bills. They feel a great deal of anxiety and fear about their paying for services they cannot afford."

Unfortunately, for older persons in this area this gap is a problem. According to the local Social Security Office, in 1983 Medicare assignment was accepted less than 10 percent of the time by 73 percent of Rock Island County doctors submitting 100 or more claims.

Suggestions to control Medicare costs by instituting a freeze in physician fees will only compound this problem if doctors are allowed to simply pass their increased charge along to the patient. We are encouraged by the recent passage of legislation allowing physicians to participate in a Medicare payment freeze. However, this does not go far enough because there is little incentive for physicians to join the program. For this reason, we urge the adoption of a plan requiring all physicians participating in Medicare to accept assignment.

The advances in modern medicine have led to longer and more full lives for older persons. As great as these advances are, however, they are of no benefit to those older persons who do not have access to them.

I would like to state again, any solution to Medicare's financial problems which substantially increases the older person's share of their medical costs is no solution at all.

What solutions do we recommend? Basically, we feel that some form of governmentally mandated comprehensive cost containment

system, encompassing both physicians and hospitals, has the best chance for success. This cost containment plan must include all payors to be effective. Further, it is our feeling that prospective payment reimbursement is crucial to any meaningful containment plan.

There are other approaches to the problem. Health maintenance organizations and preferred provider organizations are two approaches which help limit costs for their members. Because of the importance of Medicare revenues, many senior groups have successfully negotiated "preferred provider arrangements" with hospitals, which reduce their hospitalization charges. The problem with this approach is that it is not a national solution. It is not really controlling hospital costs. It is just insulating members of a preferred group. No doubt, as medical costs increase in general, much of this increase will eventually be passed on to members of the plan. Furthermore, it would not be in anyone's best interest for Medicare to negotiate with hospitals in a given area to get the best price and then require all Medicare patients to go to that one hospital.

In concluding, Senator, we have raised what we believe are the major issues facing Medicare. We have also made some rather strong recommendations for reducing health care costs. We truly believe that further Band-Aid reforms will fail.

Low- and moderate-income older persons that require hospitalization and doctors' care will not be served by Band-Aids. If we are serious about dealing with this problem, we must act in a manner that will provide controls as well as incentives, aimed at preserving health care for all Americans.

To us, this entails reduced costs and incomes for hospitals and doctors through a Government-mandated cost containment program, while ensuring an adequate level of care, regardless of ability to pay, program.

Finally, the enactment of these reforms will take great courage by Congress and America. We urge this committee and you, personally, Senator Percy, to take the lead in enacting these measures.

I would like to thank you again, Senator Percy, for this opportunity to present the concerns of older persons in western Illinois.

If you have any questions, I would be happy to answer them now.

Senator PERCY. I thank you very much, indeed. [Applause.]

I think both of you have rendered very valuable service by your appearance and your testimony.

Let me just parenthetically add that there are certain benefits to holding hearings out of Washington. I don't know that any applause is ever permitted in Washington, and certainly not in the Senate Chambers. But the Chair has the ability to rule or not rule on applause, and I think applause for this testimony is well warranted.

Second, you can't get a cup of coffee inside the hearing room there, and you certainly have warm hospitality in the Martin Luther King Community Center here. We appreciate very much the courtesies offered to us in having it here.

I'd like to ask Mr. McIntire what the impact on beneficiaries would be, as has been advocated by some experts, of having some additional cost sharing borne by beneficiaries. I'm not talking

about shifting, of course, the entire burden—that would be unthinkable, in saving the Medicare Program for the elderly—but some experts have said that some slight increases in premiums, deductibles, or coinsurance might be necessary. How would that affect beneficiaries, and how much of an increase, if any, do you feel might be acceptable?

Mr. McINTIRE. We realize that there's going to be some increases in the deductibles, and the premiums that we pay for Medicare part B.

We also recognize that we're thankful for Medicare part B, because basically the Government does pay 75 percent. Actually, I think they're paying a little more than 75 percent right now. But, in general, what we are mainly interested in is the fact tbat probably just one-third of those over 65 have fairly good incomes, another third are in the lower income brackets, with 15 percent of these in poverty, and 15 percent or close to 15 percent near poverty. Another third is in the middle of the range, and have barely adequate incomes to get by. As my grandmother would say, "They don't live very high on the hog."

In objecting to means testing, we don't particularly care about the effects on this upper third in income level. However, under means testing, Medicare would essentially become a welfare program. Only those in poverty or near poverty would get any benefits. Actually, those 15 percent in poverty have Medicaid, and would not be hurt. The one-third of those over 65 who have incomes barely adequate to live on would be hurt the most.

So that is our objection to means testing. We don't care if somebody who makes $100,000 would have to pay, but in order to do that, we think you're going to hurt the rest of the program, and we don't think it's worth it.

Senator PERCY. Thank you.

I've been studying health maintenance organizations and their impact. What is the elderly's attitude? Is there any kind of consensus toward them? Are the elderly ready to accept the HMO concept which necessitates—necessarily minimizes their freedom of choice to help contain health care costs?

Mr. McINTIRE. Is that for me?

Senator PERCY. Yes, sir.

Mr. McINTIRE. In this region, Deere & Co. has an HMO. Every year, Deere retirees have the option to go from the regular system that they've had in years past, into the new system of the HMO's. Those retirees that I have talked to are a little suspicious of HMO, and I don't quite know why. In my own case, I have resisted going into the HMO because my spouse has a special medical problem which makes it necessary that she go to the Mayo Clinic every 2 or 3 years for a checkup. If you join this HMO you must accept the recommendation of your family doctor. If the family doctor tells you that you can't go to the Mayo Clinic, then Deere & Co. would not pay for anything at the Mayo Clinic. So for that reason, I'm resisting HMO. But I do recognize, and I think that most of us recognize, that they're quite valuable, and I may change my mind.

If a representative of Deere & Co. could come to our organizations and talk about this and answer questions, I think the HMO would be more popular in the Quad City area. It's difficult to get

information from Deere & Co. on this. They get out a pamphlet, and they say there, "Yes, you must accept the recommendation of your doctor before you're referred."

But if you call Deere & Co., which I have done you never get through to anyone of authority. They refer you to someone at the place from which you retired.

I think there's a lot of value in HMO's. I may want to join next year, but I'm going to have to be convinced that I have at least as much freedom as I have now.

Senator PERCY. Well, I hope you can be convinced that there's an Illinois advantage in the senior Senator, and I just think I can assure you that if you want someone from Deere & Co. to come to the AARP and explain their program and subject themselves to questions and interrogation on it, I'm sure they would. I'll ask Chairman Bob Hanson if he will do that. If you'll just give me a little written memorandum before I leave, making that request on behalf of the organization, I'm sure they'd be happy to comply.

Mr. Halx, you stated concerns about the difference between what physicians charge and what Medicare pays. I also note, from talking with seniors around the state, that there's a great deal of concern about hospital charges, of course.

Is people's support for cost control measures equally enthusiastic for controls on doctors' fees as on hospital charges?

Mr. HALX. Yes, I would say so, very definitely. Very definitely. Like I say, some of the problems the physicians have, they're really—well, I guess now they are on a freeze for 14 or 15 months. But, like I say, it doesn't give them any incentive to get into the program, so to speak. You know, where's their incentive? But I just don't think that approach is very good, myself. I really don't.

Senator PERCY. You and Mr. McIntire both referred to new prospective payment system in your remarks. Does the average Medicare beneficiary know about and understand this new prospective reimbursement system that's now in effect or being phased in?

Mr. HALX. I think most of them do, yeah, really. You know, just relating a little bit more on HMO's, you know, you just can't join an HMO, as you well know. That's a group-type situation, where they set up a certain plan with John Deere, International Harvester, Alcoa. You can't get in as an individual, and you can't get in if your shop is not involved with the program. So, so far, that's not open to just everybody. But I think the program eventually would work pretty good, because it is a preventive maintenance type program.

But like I say, you know, just fast, just briefly, and I know you've heard it before, and not speaking for the organization but from my own personal opinion, I don't know why we're not getting—you know, somebody's not getting into a national health insurance program, because that's eventually the only answer that I personally can see to take care of this whole problem. With all this mess of paperwork of insurance companies, Medicare and Medicaid, I think it would be real great if we had one central organization handling this total health insurance program.

There's a lot of problems with all that, I realize, but it's worked for years and years in Canada and Finland and Sweden and Ger-

many. I don't know why it wouldn't work over here. And we'd get rid of a lot of these problems we have right now with health care.

That's just a personal opinion.

Senator PERCY. Thank you very much.

Let me just ask a last question of both of you.

Stepping back now and looking at the whole health care program that we have and the problems that we face with our 65 and older population, I'd like to just put this question:

Do the elderly in the United States have adequate access to health care, and how might this be affected by changes in the future, that you see coming along?

Mr. MCINTIRE. I think that in this country, because of Medicare, they do have access to the health care field, and those that probably don't have the proper access are those who have retired a long number of years ago on low pensions that have not kept up with the cost of inflation. Also, those who have never worked within the social security system and do not have Medicare. Some of these people have a very, very rough time, and there's a lot of them in Illinois. I speak in particular of retired rural teachers, one of the biggest disgraces that Illinois has had, with the low pension payments to some of these people. While it has been corrected to a great degree, many of those people don't have Medicare, and it's expensive for them.

I'm quite sure that with the numbers of the old that we have in this country, and our numbers are growing larger every day, that politically we should be able to hold our own in future years and get adequate health care.

Thank you.

Senator PERCY. Very good. Thank you.

Mr. Halx.

Mr. HALX. Real briefly, Senator, I'm a little concerned—Personally I get a little teed off at times because I know there's problems in hospitals and doctors and problems with this whole program, but also we have to be concerned about certain people changing the way of spelling health to spelling wealth, and I think that's got a lot to do with it. We do have certain elements in our society who are out to make a buck any way they can, and they're not really concerned about the health program. And I think if we could stop a lot of that—of course, that goes on in a lot of fields, not only the health care field—I think that would help tremendously too.

But basically I think we're on the right track here, and I think what you're trying to do here I believe is a real good thing, in having these field hearings and getting people's information into yourself, and you can sort it out with your people and, by golly, maybe we can just get something going on this here in the next few years. We certainly have to hope for it, anyway. That's what we're here for, and hope you can get it done, Senator.

Senator PERCY. Very good.

Mr. MCINTIRE. Could I have one more comment?

Senator PERCY. Of course.

Mr. MCINTIRE. While we are somewhat critical of doctors and the hospitals, I would like to add that there's a lot of the old that expect to live another 20 or 30 years, and along the road we do want to have hospitals to go to. We want good doctors and a good

medical system, to take care of us. So while we're interested in maintaining our own benefits, we're also interested in maintaining the health of the health care system.

Senator PERCY. I thank you very much, indeed. You've been fine witnesses, and we very much appreciate your appearances. [Applause.]

Our final panel, Dr. George Burke, Mr. Tim Kearns and Ms. Ruth Lee.

We will, by the way, at the conclusion of this final panel, have an opportunity for the press to ask any questions and also—do we have forms available, by the way? I'd like to do something we've not yet done in anything I've conducted in 18 years. But I think in this case, where it affects all of you, or people close to you, so much, that it would help us for our record to have any questions or comments that anyone would like to make to the committee. I can then take those back to Washington and share them with the staff and with our committee members—Senator Heinz is the chairman of the overall committee. So any comments that you have, I would value your writing them out and leaving them right here with us.

Because I did not get a chance to say hello to all of you, those of you who wish to stay for the press conference can, and the others, I would be very happy to say hello to just as we leave for the airport.

Now, if we could have this final panel, Dr. George Burke, radiologist at Franciscan Hospital, will proceed first; to be followed by Mr. Tim Kearns, director of fiscal services at Lutheran Hospital; and by Ms. Ruth Lee, executive director of the Iowa-Illinois Health Care Alliance.

STATEMENT OF DR. GEORGE H. BURKE, RADIOLOGIST, FRANCISCAN HOSPITAL, ROCK ISLAND, IL

Dr. BURKE. Senator Percy, fellow panelists, distinguished visitors, and friends, I am Dr. George H. Burke, practicing physician in Rock Island, testifying in behalf of the physicians of Rock Island County. We appreciate this opportunity to offer testimony, although in 7 minutes it is difficult to more than barely scratch the surface of the crisis in Medicare.

I would like to address three main issues: The recent Medicare fee freeze, prospective reimbursement, and professional liability.

First, let's talk about Medicare's prospective reimbursement. This has to do with hospital reimbursement at the present time, and is managed through what are called DRG's, standing for diagnosis-related groups. DRG's only cover Medicare part A hospitalization. What it does is to concentrate solely on cost instead of concentrating on quality medical and health care. I think it is safe to say there isn't a physician who won't be affected directly or indirectly by DRG's; therefore, it is important to realize what it will mean for our patients and the care they receive.

The DRG concept was approved by Congress and is now the law of the land. Organized medicine had hoped that such a revolutionary system would be tried experimentally, so that results, both positive and negative, could be evaluated before expanding this concept for all Medicare patients. Basically, the system is based upon 23 major diagnostic categories that loosely relate to the sys-

tems of the body. These are subsequently broken down into 468 diagnostic related groups. The plan is to control Medicare payments by sorting patients into one of these groups.

In theory, the belief is that patients are lumped into each category as being medically similar, in that all will require the same length of stay and receive similar procedures for treatment. The hospital receives one payment for each patient placed in a specific category, regardless of complications or resources necessary to treat the patients. There are some rules to allow for serious exceptions to the norms established for this program.

Certainly, some patients will utilize more hospital resources than others, and some patients will take longer to heal than others. In these cases, the hospitals are at risk to absorb the differences between Medicare payment and actual expenditures of staff time and services rendered. The medical society and all physicians are concerned that our patients continue to receive good quality medical care and remain committed to working with the hospitals and our patients to ensure that they are not adversely affected by Federal intervention in the practice of medicine.

It is too early to tell how effective this experiment will be. The medical profession will continue to monitor the impact of this system on quality of care, since there are still unanswered questions concerning professional liability in relation to practicing medicine within these guidelines: That is, the decision to perform or not perform certain tests, because they will not be reimbursed by the program; the decision to treat patients in settings other than hospitals; the pressure by hospitals for early discharge of patients because of national norms, all impact severely on the rising costs of professional liability insurance costs.

With the continued rise in liability premiums, medical practitioners will, by necessity, be forced to pass those costs along to patients via increased fees.

My final topic has to do with the recent Medicare fee freeze. You may have read or heard in recent news accounts about changes that the U.S. Congress has made in the Medicare Program, and you may be concerned. You should know that the majority of these changes are directed at physician reimbursement rather than at the patient. I want to assure you that despite these changes in reimbursements, the care physicians provide to patients will not change. Earlier this year the AMA urged physicians to freeze fees for a period of 1 year. The Illinois State Medical Society joined the American Medical Association in supporting the freeze, as did the Rock Island County Medical Society.

Subsequently, physician fees were frozen by the Health Care Financing Administration for a period of 15 months, requiring by regulation what was being accomplished in a voluntary manner.

Under this proposal, Medicare has created two classes of physicians for purposes of paying bills: Those called participating, who accept assignment on all claims for all Medicare patients, and those called nonparticipating, who find it appropriate to accept assignment on a case-by-case basis.

"Assignment" means that the physician accepts what the Government pays, plus the required 20 percent billing to the patient. No matter whether a physician is participating or nonparticipat-

ing, the Government has frozen its payment levels at those set earlier in 1984, and they will remain frozen until October 1, 1985. The new law has eliminated any increase in payment for 1984, and has delayed it until at least October 1, 1985. Under this proposal, many physicians will have serious economic factors to consider before deciding to become a participating physician.

I encourage Medicare recipients to consult their physician to discuss the impact of this regulation on his practice of medicine.

Thank you for the opportunity to be with you today.

Senator PERCY. Thank you very much, indeed, for a straightforward explanation of this difficult concept.

Now we'll be happy to have you start in, Mr. Kearns.

STATEMENT OF TIM KEARNS, DIRECTOR OF FISCAL SERVICES, LUTHERAN HOSPITAL, MOLINE, IL

Mr. KEARNS. Thank you, Senator Percy. I represent Lutheran Hospital, a 230-bed, not-for-profit, acute-care hospital. Lutheran Hospital has participated in the Medicare Program since its inception. We have a September 30 yearend, and thus have been in the prospective payment system since its inception. Last year, we had 59,194 patient days, and an occupancy rate of 71 percent. This year we anticipate 51,000 patient days, and occupancy rate of 61 percent. Our Medicare percentage of patients is 55 percent. We have seen many changes over the last 18 years, but none quite as dynamic as the new prospective payment system.

What we would like to talk about today is our perceptions of this program, specifically its intended effects, its unintended effects, and our concerns for the future and our recommendations.

The prospective payment system, we feel, was intended to reduce costs of service, unnecessary utilization of hospital services, to minimize duplication of services, and unnecessary use of high-cost technology. It was also intended to increase physician awareness of the cost of care, increase price competition among hospitals, and develop new, efficient forms of health care delivery systems.

These concerns and intended effects are shared not only with the Federal Government, but by other payors, physicians, the public, and by Lutheran Hospital. Until recently, our perception of the PPS development has been marked by cooperation and communication with all interested parties. We are convinced that the Government's objectives, as well as those of health care organizations, will be best served if we work in a cooperative manner.

At the same time Lutheran Hospital was anticipating the prospective payment system and reacting to the system's intended effects, we also foresaw potential problems inherent in the system. These effects included increased cost shifting, reduced quality of care, reduced access to health care delivery systems for Medicare beneficiaries, and inhibited growth of new technology.

Lutheran Hospital has always been committed to cost-efficient delivery of health care. We have also been committed to high-quality care for our patients. The unintended effects I have listed above are now making Lutheran's commitments harder to achieve. We may now both have to redefine the quality and quantity of care as we face the challenge of where available resources will best be

spent. Once we cut cost to its lowest level, it is increasingly more difficult to continue achieving new savings each year.

We can increase the productivity only a limited amount. Our concern is that with an ever-aging population, it is probable that health care costs will rise faster than the overall economy, and that the progress in cost cutting we are making now will not be sustained over the long term. If, over the foreseeable future, we cannot or will not be reimbursed for our full financial requirements, the quality of care will most likely have to suffer.

Three areas of concern that we would like to address—and these relate to the July 3, 1984, proposed regulations—proposed changes in the prospective payment system—are the downward adjustment of the DRG weights, capital cost, and budget neutrality.

We feel that the reduction of the relative weights is inappropriate for the following reasons:

Specifically, the method of calculating the adjustment, and the nature of the adjustment.

The method first assumes that the same services are given every year, and is an incorrect basis for the adjustment. The method assumes that discharges by month are uniform within each hospital each year. For example, the calculation assumes that hospital A always serves the same proportion (number) of myocardial infarction patients every March. There is no available data that supports such an assumption for this type of analysis.

Second, the reasonableness of the sample used also raises questions. Since only those hospitals under the Prospective Payment System through March 1984 were used, each hospital is weighted only for the months it has been on PBS. It appears there was no adjustment for any phase-in characteristics unique to hospitals that were only in the system for 1 or 2 months of the study period.

Finally, there is the question of whether the hospitals sampled are representative. Many hospitals have fiscal years beginning after March and are, accordingly, excluded from the sample. We understand from other data that hospitals with later starting fiscal years tend to be larger than average, and represent a substantial number of discharges. The new regulations will be used to adjust payment for all hospitals, even though many are not represented by the sample. Because of their size, hospitals excluded from the sample would have a significant influence on the results.

As far as the nature of the adjustment, the main things we feel need to be looked at in the nature of the adjustment were not used. The method adjusts for changes in case mix for any and all reasons. These reasons could include: Improved accuracy of coding; service to patients who required and received a higher order DRG than previously, because of technological advances, an aging population, and other reasons; an increase in the average case mix index due to a shift of some cases to outpatient service.

Since the method utilized measures and adjusts for the aggregate changes in case-mix, all of the above types of changes (and probably others) are included in the adjustment.

Lutheran believes that a change in case-mix rate should not be adjusted. We believe it is inappropriate to make a general adjustment for any of the types of changes listed above. Improved accuracy in coding was an anticipated effect of the system, and was previ-

ously adjusted for. Therefore, no further adjustment should be necessary. Medicare cases that require more intense treatment should be paid for at the value of care provided. Increases in case-mix resulting from a shift to outpatient services should not be adjusted because Medicare saves on these cases by not paying for an inpatient case. Adjusting the DRG weights for these elements results in an inequitable double savings to Medicare.

As to capital costs, at the present time hospitals are receiving a pass-through on capital costs along with their prospective payments. Lutheran Hospital, as well as many other hospitals, may come out reasonably well for the short term. However, once capital is incorporated into the prospective rate, our concern is that we may have difficulty in recovering our capital costs. A hospital with a high debt-to-equity ratio will have severe problems in obtaining reimbursement for full financial requirements.

Our recommendations are as follows:

Capital should be classified according to inpatient and outpatient components. PPS addresses only inpatient activities, and we believe the capital component of the system should be no different.

Capital expenditures made before the implementation of PPS should be treated differently than capital expenditures made after implementation. Such a concept would give consideration to the different environment under which hospital management made decisions before PPS, while putting reimbursement at risk for decisions made under PPS.

Hospitals should be given a reasonable transition period, paralleling the normal capital cycle, to adjust to any new methodology.

Any methodology adopted must contain a reasonable formula containing reasonable rates.

The planning process should remain under the jurisdiction of the current Illinois certificate-of-need program.

I have not read nor seen evidence that hospitals have abused the capital pass-through provision. In fact, many of our colleagues have raised the point that the future is too insecure to make commitments which may go unreimbursed.

Ever present in our minds has been the presence of the budget neutrality provision of prospective payment legislation. As we understand budget neutrality, it was Congress' intent that HCFA pay in accordance with the PPS formula, but with the restriction that overall spending may not increase beyond what would have occurred under TEFRA limits. A routine discussion in our hospital is "How is the government going to implement budget neutrality." The proposed regulations discuss the methodology and legislative mandate for the calculation. The methodology described attempts to calculate what the average cost per discharge would be under the Tax Equity and Fiscal Responsibility Act [TEFRA] as a ceiling on PPS payments.

The change in aggregate payments in the proposed methodology is calculated on a per admission basis. This has necessitated numerous assumptions about how hospitals are responding to PPS, how hospitals would have responded to TEFRA and other matters. While the proposed methodology assumes admissions are constant, a change in admission should not be penalized by the payment system. Our actual experience shows that the rate of growth in

Medicare admissions is dropping, which we believe is evidence that we are responding to PPS incentives.

We have concluded that the admission basis for the budget neutrality calculation violates the "aggregate payment" criteria and requires the use of many assumptions that are subject to question. We believe that a methodology that focuses on program aggregate payment is more appropriate. TEFRA's per admission methodology is insufficient reason to calculate PPS limits on a per admission basis. HCFA should abandon its per admission approach. We believe Congress' intent was that total program aggregate payment is the proper basis of the budget neutrality limitation.

My final comments with regard to how we can effectively carry out the Medicare Program:

It is apparent to Lutheran Hospital that in order for us to carry out our goals of quality patient care in the most cost-efficient manner to the patients, to the elderly and disabled Medicare beneficiaries we serve, adequate reimbursement must be made by the Medicare Program. We are willing to work within a fair system of payment. We suggest to you that to propose changes in a system virtually untested is not fair, and certainly inappropriate.

We suggest to you that we all let the system work before a major overhauling occurs. The key, as we see it, is stability. We urge Congress to allow prospective payment system and health care providers to prove themselves before extensive changes are made. We believe that changes to budget neutrality, capital costs, and lowering of DRG's relative weights, as previously mentioned, could undermine health care before it has a chance to work.

I did not elaborate on other issues, such as elimination of the 1 percent technology factor and pass-through for medical education costs, or the phase-in to the national rate. These issues also deserve your attention.

We believe that other groups and individuals are staging cases for hospitals and health care in general, and they also deserve your attention. Lutheran Hospital is committed to working with organizations such as Health Care Financial Management Association, American Hospital Association, Illinois Hospital Association, and the Greater Quad City Hospital Council.

With your help and our joint efforts, reasonable solutions to health care costs and benefits can be achieved for the aged and disabled beneficiaries of the Medicare Program.

One other point I would like to bring up at this time is the increase, particularly in Illinois hospitals, over the last year. Our rate of increase was one-half the national average, here in Illinois. So this system and other systems are working. Again, we'd like to propose that we let the system work before we make severe changes to it.

Thank you.

Senator PERCY. Thank you very much, indeed.

We will now hear from Ms. Ruth Lee.

STATEMENT OF RUTH J. LEE, ROCK ISLAND, IL, EXECUTIVE DIRECTOR, IOWA-ILLINOIS HEALTH CARE ALLIANCE

Ms. LEE. Thank you, Senator Percy, on behalf of the Alliance, for inviting me to make a presentation this morning.

The health care system currently is in the midst of dealing with pressures and incentives for change, the like of which have never been experienced. Major payors, public and private, concerned about the alarming rate of increase in health care costs, are seeking ways to alter payment mechanisms and provide other incentives to reverse this trend, while ensuring that high-quality care is not jeopardized.

In the first part of my presentation, I will discuss local activities underway to address the cost issue. Then I will briefly address the Medicare system and related issues.

Locally, much is being done to address cost containment and bring about positive changes in the system. Just 4 short years ago, Deere & Co. and organized labor sponsored the development of a community health maintenance organization here. The Quad City Health Plan is thriving. It has 18 companies and 56,000 area residents participating. And, by the way, it's looking forward to enrolling Medicare beneficiaries after the first of the year. Because of the close working relationship with physicians in the Independent Practice Association, hospital inpatient days for plan enrollees have been reduced to 445 days per 1,000 enrollees, compared with a 1980 level of over 1,000 days per 1,000 area residents. Physicians locally have been early and active participants in ongoing utilization-review activities.

In addition, local industry is now working to negotiate prospective payment arrangements with participating providers. In at least one instance, the arrangement is based on diagnosis-related groups.

With assistance from the Midwest Business Group on Health, local employers are banding together to form a business coalition specifically to address health care issues of importance to them. We at the Alliance look forward to working with them in the future.

Educational activities are underway through employer and labor groups to inform their constituencies about cost-related issues. The goal is to encourage employees to become prudent buyers of health care services.

The Alliance itself is the sponsor of a resource reallocation project, funded in part through the Robert Wood Johnson Foundation's initiative, entitled "Community Programs for Affordable Health Care." Within the next few months, we shall be moving from the planning phase of the grant to implementation. The intent of the program is to identify the level of excess capacity in the local health care system, and develop programs designed to promote necessary changes. Representatives of local business, labor, and provider groups are participating in the project.

The problem of excess hospital inpatient capacity has been developing for several years. The level of the excess capacity has increased rapidly with the implementation of utilization-review programs and, most recently, of Medicare's prospective payment system. Coupled with the increasing emphasis on cost containment

by employers and insurers, the issue of excess capacity is of major interest in this area. In the Quad City metropolitan area alone at the present time there are an estimated 300 to 400 excess beds. One does not have to go very far to hear talk of options such as consolidation, sale, closure, and so on.

However, excess capacity is only part of the issue. Downsizing the acute inpatient care system and appropriately diverting resources to other areas of need require the availability of comprehensive information bases about expenditures, costs, utilization, demographics, and so on.

Implementation of a prospective payment system based on diagnosis-related groups, or DRG's, for Medicare beneficiaries is a major step in changing the incentives for the use of various levels of health care services. While the system undoubtedly will be refined and improved, and may even be just a first step in an evolutionary process, it is a crucial first step.

The diagnosis-related group pricing mechanism used by Medicare focuses on part of the issue—that of length of stay. The other part of the issue—admissions themselves—also must be addressed. Recent studies have shown tremendous variations in the use of Medicare dollars among geographic areas as small as counties, or even municipalities within counties. The difficult issue of standardizing utilization, at least to some degree, will have to be addressed.

The reimbursement differential between urban and rural hospitals also is of concern in this area. It cannot be assumed that the cost of operating a hospital in a rural area differs drastically from an urban area. It appears that, under the current system, many of the Nation's rural hospitals will be in serious financial trouble.

It is increasingly important that representatives of all groups work together to develop solutions to the major health care issues facing us. Public and private sectors must work together. Provider groups must remain actively involved. Local health planning bodies, such as the Alliance, must become more active and visible.

This country, which has prided itself on having the best health care system in the world, suffers from the lack of a consistent national health care policy. The development of such a policy is difficult, because we have not opted for a national health care program or national health insurance, neither of which I am advocating at this time. However, in this era of shrinking resources, we must face, head-on, major issues, all of which relate in one way or another to our inability to pay for total health care benefits for everyone, either through public or private funds.

The Medicare Program itself is faced with the potential of bankruptcy in the near future. We must decide whether to reduce benefits or face the fact that it no longer can be operated as a universal entitlement program. Major issues of social justice, including rationing and access, suddenly are gaining attention. The tension within the system between a truly competitive versus a highly regulated environment seems to be increasing.

The knotty problem of how to get unit costs under control, while still reducing utilization, is just beginning to be addressed, mainly through prospective payment mechanisms. Issues related to payment of capital costs through Medicare, physician reimbursement mechanisms, and standardizing utilization patterns are not re-

solved. The acute care system still is viewed as a discrete entity, as if it were not related to other crucial health care services. In fact, without some rather immediate intervention, our long-term care system probably will soon replace acute inpatient care as our major area of concern.

Resolving these and other pressing issues will take the consolidated effort of all segments of the health care industry, including providers, business, industry, labor, insurers, legislators, consumers, and planners. Putting aside parochial interests to work toward identifying and achieving common goals for the overall good of our society is no simple task. However, it must be done.

While we deal with cost and quality issues, whether through the Medicare system or any other payment system, we must always keep in mind the ethical and social principles which led to the expansion of our publicly funded programs in the first place. While sometimes flawed in the implementation, nevertheless these principles are what characterize us as Americans.

To quote Willis Goldbeck, publisher of Business and Health:

> The major objective is to trigger a dialogue in which the ethics of cost management and of societal tradeoffs are given as much attention as the concern over cost itself.

Again, I thank you for the opportunity to be here today.

Senator PERCY. Thank you very much, indeed. That truly is a very, very encouraging body of testimony that you have given us today: That 56,000 residents in this area, over a period of 4 years, have actually cut in half the number of inpatient days in hospitals is truly remarkable. That is one of the reasons, by the way, that I selected the Quad City area to come to. I didn't come to the worst area; I came to one of the best areas, one that has done the most in recent years to address this problem, and offer a hope to the Nation that by coming together, by really working together in an alliance, certainly with the cooperation of the medical profession here, and the hospitals. Certainly, a business coalition has been formed, operating and working with unions. This is truly a model case that we can present to the country. It can be done. And I think it's almost in the spirit of the Olympics, that we've all captured, that through hard work, determination and setting an established goal, we can prevail, and we can overcome these problems.

So I really commend you very much, indeed.

We have just a few moments left, and I wonder if I could ask that you be very concise in your answers, and then we will leave the record open so you can amplify them for the record just as much as you want.

First, Dr. Burke, before Congress acted to freeze physician fees and encourage doctors to accept patients on assignment, there was talk that some doctors would drop out of Medicare, rather than accepting Medicare rates as full payment for services. Because so many doctors, however, get a sizable portion of their income from Medicare, was that just an idle threat? Do you see many physicians dropping out of the program?

Dr. BURKE. I don't as yet, Senator, but I would wonder what is going to happen as the DRG system—if DRG's are then extended to the physicians, I think we may see more dropping out. Certainly

the older physicians are getting a little tired of regulation, and may well opt to retire. We don't know what the younger ones are going to do.

Senator PERCY. There was sort of a warning signal there.

In your testimony you expressed some serious concern that the new Medicare prospective payment system could adversely affect the quality of care by forcing doctors to take shortcuts in order to keep hospitals in the black. Is there any evidence that is happening, and what can be done to combat the problem?

Dr. BURKE. Well, I think the PRO's hopefully will help to control that, but we are concerned about the impact of decreased length of stay mandated by Federal regulation. Also, whether we're going to start rationing care.

We would also worry about the effect it might have on professional liability, because if we are going to have to have another standard of care, are we going to be judged on a liability situation by the upper standard of care, as compared to the lower? We have a liability crisis in this State. We project, based on good figures, that one out of three physicians in this State will be exposed to a lawsuit this year. So I think we have a very real problem.

Senator PERCY. Thank you very much.

Mr. Kearns, you mentioned reduced access to health care delivery systems for Medicare beneficiaries as one of the potentially unintended effects of the prospective payment system. Do you then believe that the current system will induce hospitals to discriminate against patients whose payor will not pay the full cost of care—in this case, meaning Medicare patients? Is Lutheran Hospital being forced to favor private-pay patients and deny access to more unprofitable patients, for financial reasons?

Mr. KEARNS. No, at the present time we're certainly not doing that. That's certainly not our intention. We hope never to do that.

The case we're stating is that we don't have that problem right now, so why change? We've got a good health care delivery system. Let's continue what we have. We want fair reimbursement. I believe we need that to operate our facility. If we continue to cut, that's certainly a possibility. We may not have the resources to apply all the services that the community is asking for and which the community deserves.

Senator PERCY. I was told some time ago, when inflation was running much more rampant, double digit rather than 3½ percent that we now have, that four-star hotels in 10 years would be charging $1,000 a night for a room or small suite. Are there any projections that have been made as to what, 10 years from now, hospitals might charge? Let's just assume that it's low double-digit inflation—and I hope that will scare us enough not to have that. We've now gotten it down, and I think we're used to this idea that we don't have to have inflation in this economy, and we can get it down, which helps everyone, particularly low-income people.

But are there any projections ahead that you've ever seen?

Mr. KEARNS. Well, I certainly don't have any, 10 years down the road. It's very difficult at this time to even project 2 and 3 years down the road what our costs are going to be. You know, it's not only the costs that we have for the labor that we pay for, but we have other suppliers out there who pass those costs on to us also.

So, 10 years from now, no way would I——

Senator PERCY. Thank you very much.

Ms. Lee, in your comments you mentioned that either Medicare benefits must be reduced or the program must no longer be operated as a universal entitlement program. Which of these options do you actually favor, yourself; reducing benefits, means-testing as a program, some combination of the two, or yet another approach?

Ms. LEE. I'm not a fan of reducing benefits. I'm also not a fan of means-testing. As I've been talking with people about this, the approach that seems to me to offer the most promise is, in some form, making Medicare benefits a taxable item. And I think that—because I want to follow up on the other gentleman's comment about the third, third and third, if you will, in the income levels—if you make Medicare benefits taxable income, then the people who can afford to share more in the cost of their care will be doing so, thus increasing the revenue side and avoiding the onerousness of a means test and avoiding, I think, an additional bureaucracy that would be needed if means testing were implemented.

Therefore, the best alternative I see is making them taxable benefits.

Senator PERCY. Thank you very, very much, indeed. You've been a fine panel.

This will conclude our hearing. I would urge that anyone who would like to have a printed copy of this hearing either leave a slip of paper right on this desk as you go out, with your name and address on it, clearly printed, or we can just arrange for you to—why don't we just say Mayor Anderson will make arrangements that anyone who wants to can drop a note to him, and he'll bundle them all up and send them to me. Mayor Anderson will then be happy to forward to me the information so that we can send direct mailings to you.

Any of you that have comments or questions that you'd like to leave with us, do that also. If you think of it while you're driving home, or tonight at home, then drop a note to Mayor Robert Anderson of Moline, and he will be happy to act as our conduit for forwarding those to me.

If there's no further business, then, this meeting is adjourned.

[Whereupon, at 11:05 a.m., the hearing was adjourned.]

APPENDIX

STATEMENT OF THE VISITING NURSE AND HOMEMAKER ASSOCIATION OF ROCK ISLAND

Visiting Nurse and Homemaker Association [VNHA] of Rock Island County is a voluntary not-for-profit home health agency which has served the community since 1903. During the past year, VNHA made 7,333 skilled home nursing visits of which 5,353, or 73 percent were reimbursed by Medicare. VNHA made 1,664 home health aide visists and 1,060 of these, or 64 percent, were reimbursed by Medicare. VNHA also provides a number of Medicare reimbursed physical therapy, occupational therapy and speech therapy visits to elderly persons at home.

VNHA would like to offer comments on two Medicare issues: The definition of "intermittent care" and the selective billing or coordination of benefits issue.

Definition of Intermittent Care

In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24-hour-a-day care. The present guidelines allow for daily visits for a maximum of 3 weeks. Thereafter, visits may be continued upon a showing of exceptional circumstances. Moreover, the guidelines have permitted more than one visit to the same patient on the same day, perhaps one visit from a nurse and another from an aide depending on a showing of need. Information collected from a number of States indicates that various restrictive interpretations of the term "intermittent" are being imposed by some intermediaries. In some instances, it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances, clients who are in need of and who receive services 5 or even 3 days a week are being deemed as in need of daily care and therefore not compensable. There are even reports that such determinations made in the present based on restrictive interpretations are being applied retroactively resulting in retroactive denials.

The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy, and other services into the hands of home care agencies who are being told that they cannot care for them because they need more than intermittent care. With the hospital prospective payment plan now in effect, the problem is likely to be exacerbated, with patients being released from hospitals more quickly and in a sicker condition. The further irony is that government policy is pushing many clients into institutional settings when they prefer to stay at home with resulting increased costs to the government.

Definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's interpretation. As a result, what is supposed to be a national program is not enforced uniformly and what is covered for one beneficiary in one State is not covered in another State.

Congressman Henry Waxman introduced legislation (H.R. 3616) a bill which would define intermittent care to include one or more visits per day on a daily basis by a nurse or a home health aide for up to 90 days, and thereafter under exceptional circumstances, with monthly physician certification of reasonableness and necessity. Senator John Heinz sponsored an amendment to a deficit reduction bill which would permit one or more visits a day of daily care for a period of up to 45 days in cases where a client has been discharged from hospital to home care. Neither the House legislation nor the Heinz amendment has been enacted.

VNHA strongly endorses legislation like the Waxman bill which would make the intermittent care definition more congruent with congressional intent and other regulations. This would have the effect of making essential home health services available to elderly persons who need them.

COORDINATION OF BENEFITS

Some fiscal intermediaries inform home health agencies that if patients receive coverage under Medicare they cannot receive additional coverage from Medicaid or any other source of payment (private insurance, self pay, etc.)

For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare and wants an additional 2 hours of nursing care the other 2 days to be paid by concerned relatives, Medicare will deny the Medicare coverage.

Medicare's logic for such denials is that if a person receives coverage beyond what Medicare will cover then the person needs more than "intermittent care" and is ineligible for Medicare coverage. Thus, Medicare is seeking to both prescribe the need (i.e., the limits of intermittent care) and to be second payor. This approach limits the availability of services to beneficiaries and availability of payment sources to beneficiaries and HHA's.

VHNA contends that a patient should be able to utilize multiple sources of payment as long as the care being received is medically necessary and reasonable and not duplicative of other care. Medicare should not be able to limit the extent of care a patient may receive merely because it exceeds the Medicare definition of need. A patient should be able to order and pay for whatever additional care he desires beyond Medicare without the fear of jeopardizing his Medicare benefits.

Our rationale is that there is no basis for such a policy in law, regulations, or HCFA manuals. It exceeds the authority granted to HCFA and its fiscal intermediaries. To allow such a policy to exist would make the Medicare benefit a "means-tested" benefit, which clearly is not the intent of the law. There are certain limited primary sources of payment which must be utilized before Medicare can pay. These are very limited under section 116(b) of TEFRA and indicate that thereafter Medicare is the first and primary payor. There is no bar on use of other payment sources in conjunction with Medicare.

The current policy discriminates against home health agencies because it seeks to deny coordination of payment sources for benefits where such coordination is permitted for hospitals. The law makes no such distinction between hospitals and home health agencies.

Further, the current policy is illogical. Where the patient receives his Medicare-covered care from one HHA and other covered care (paid from non-Medicare sources) from another HHA, both HHA's are paid and the patient receives his full coverage from all payment sources. It is illogical not to allow such coordination of benfits where the care is being rendered through one HHA.

Care should be permitted to the fullest extent possible as long as it is medically reasonable and necessary and not duplicative. The patient's initial and ongoing certified plan of treatment by a physician is the initial and ongoing basis for determining whether the person requires "intermittent care." (See section 1835(a) and 1814(a) of the Social Security Act, regulations (42 CFR 405.1633), and the stress on physician certification in section 204.1 and 206.6 of HIM-11.)

The fiscal intermediary is to make its judgment as to whether intermittent care is needed, the extent of the care, and duration of care based on the physician's certification, plan of treatment, and clinical records—not on the nature of the Medicare bill. There is nothing which bars a home health agency from providing any type of home health service to a patient on a private pay basis. There is nothing which bars a provider from providing care, approved by the physician, to a patient who pays part by Medicare and part by private pay or other sources.

The selective billing ban presumes that where non-Medicare pay sources and Medicare sources are simultaneously used to cover home health services the patient does not require "intermittent care" and the provider is trying to disguise that fact. That is an inequitable and unlawful assumption. FI's have access to all physician certifications and recertifications, to plans of treatment, and to clinical records. These reflect the type, intensity, and duration of care and should be used to determine whether, on a case by case basis, "intermittent care" is merited and being rendered. The billing process never was intended as a vehicle to reach a clinical judgment on intermittent care or any other clinically-based issue.

This policy also makes the patient and his family risk loss of Medicare coverage if they want to have more care than Medicare would allow.

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